Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 9/5/22
To 7/27/23

RETRIEE INFORMATION:

Name: [redacted]

Employee #: 50143

Address: [redacted]

Phone # [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
9/22-7/23	Payments 9/22-7/23	Anthem Blue Cross	Medical, Dental, Vision, GAP	$ 13650-23
				$ -
				$ -
				$ -
				$ -
				$ -

Medicare Eligible? ____YES __X__NO

Total ~~$0.00~~ 13650-23

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] Date: 7/28/23

PRMPT Approval*: _____ Date: _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval**: _____ Date: _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Washoe County School District
425 East Ninth Street * P.O. Box 30425 * Reno, NV 89520-3425
Phone (775) 348-0200 * Fax (775) 348-0304 * www.washoeschools.net

July 27, 2023

Re: Premium Payments

[redacted]

Per your request I have reviewed and verified your benefit payments. Below is a breakdown of your benefit premiums as well as the payments we have received from 9/1/22 – 7/27/23.

Benefit	Premium	Payments
Retiree Medical	$694.40	$7,638.40
Spouse Medical	$413.78	$4,551.58
Retiree Dental	$62.32	$685.52
Spouse Dental	$30.07	$330.77
Family Vision	$13.46	$148.06
Retiree GAP	$14.80	$162.80
Spouse GAP	$12.10	$133.10
Life Insurance	$86.60	$952.60
TOTAL MONTHLY PREMIUM $1327.53		**Total Payment $14,602.83**

If you have any questions or need additional information, please feel free to contact me at 775-348-3852.

Life insurance = 952.60
Net = 13650.23

Respectfully,

Deidrea Osgood
Lead Benefits Technician

Washoe County School District
Retiree Enrollment

Effective Date of Retirement: 8/26/22

Location Site (Required): Pine, At large

Last		MI		Em E00
Mailing Address	City	State	Zip Code	Email Address

1. **Status:** Certified___ ESP___ Administrator X Confidential___ 2. **Hire Date:** _____

3. **Effective Date of PERS:** 8/27/22 4. **Current Plan** PPO X QHDHP ___

5. **Dependent Information if covered:**

Relationship	Last Name	First	MI	Birthday	Sex M/F	Reside w/ EE Y/N	Dependent Social Security #	Email Address	Elig Docs
Spouse									
Child									
Child									

$ 756.72 Retiree Health Premium

___ Eligible for subsidy (ESP-34.75% 7/1/19-6/30/20)*

___ Medicare Enrolled

$ 443.85 Spouse Health Premium

___ Medicare Enrolled

$_____ 1 Child Health Premium

$_____ 2 Children Health Premium

$_____ Family Health Premium

$ 13.46 Vision Premium (Retiree & Eligible Dependents)

$ 86.60 Basic Life Insurance**

☐$40,000 Limit (Cert/ESP) ☐$50,000 Limit (Admin/Confidential) ☐$200,000 Limit (Admin)

___ age 70 or over

$_____ Additional Life Insurance** (Premium based on age and limits)

Value of Supplemental Life Insurance _____

$ 14.80 Retiree Gap Premium (PPO Only)

$ 12.10 Dependent Gap Premium (PPO Only)

$_____ Retiree Non-Discount Premium

$_____ Spouse Non-Discount Premium

$ 1327.53 **Total Health Premium to be pulled from PERS Check**

*The subsidy is subject to negotiations and could change. The subsidy is for ESP Staff hired prior to July 1, 1999 with more than 15 years of service. There is no subsidy for Certified/Admin Staff.

**The total combined limit of Basic Life and Additional Life that may be combined is $200,000.

Employee Certification:

With my signature, I hereby declare, certify and state under penalty of perjury that the information I have provided here is true and correct, that any dependents listed above are eligible under my Employer's Dependent Benefit Criteria. Further, I understand that the information supplied, herein, may be used by my Employer in order to verify my dependent(s) for purpose of coverage, to make decisions about my coverage under my Employer's employee benefit plans and as otherwise necessary in connection with managing the organization's employee benefits plans. Finally, I understand that if required documents have not been provided by my Employer's deadline, my non-verified dependents' coverage will be terminated.

I authorize WCSD to deduct the premiums indicated above from my PERS retirement check. I understand these premiums are subject to periodic changes. Therefore, I authorize WCSD to deduct these premium changes from my PERS retirement check as required. If premium is not deducted from PERS check, Retiree must notify and pay WCSD Health Insurance Fund directly by the 25th of the month. Failure to report any errors in premium contributions to the Risk Management Office could result in loss of contributions. A maximum of two (2) months of contributions will be reimbursed for overpayment due to [illegible] notification.

Employee Signature _____ Date Signed 8/8/2022

DISTRICT USE ONLY:

Employer Signature _____

Public Employees' Retirement System of Nevada
693 W. Nye Lane, Carson City, NV 89703 (775) 687-4200 - Fax (775) 687-5131
5740 S. Eastern Ave., Suite 120, Las Vegas, NV 89119 (702) 486-3900 - Fax (702) 678-6934
Toll Free 1-866-473-7768 Website www.nvpers.org

2023
pmts

GEORGETTE W KNECHT
PO BOX 937
VERDI, NV 89439-0937

DEPOSIT DATES MAY VARY DUE TO OFF-SITE DATA PROCESSING BY SOME BANKING INSTITUTIONS.

13416

ELECTRONIC FUNDS TRANSFER NOTICE - PERS FUND

#1077136

SCHEDULED DEPOSIT DATE:	**07/26/2023**		
GROSS AMOUNT:	**4,535.59**	RECEIVED YEAR TO DATE:	**31,777.24**
DEDUCTIONS:	**1,601.13**	TAXABLE YEAR TO DATE:	**31,777.24**
DEPOSIT:	**2,934.46**	RECEIVED TO DATE:	**49,286.58**

DEDUCTIONS:	MONTHLY AMOUNT	YEAR TO DATE AMOUNT
Federal Tax	**273.60**	**1,915.17**
MEDICAL PLAN 2	**1,327.53**	**9,292.71**

REMINDER:

PLEASE NOTIFY PERS IN WRITING OF CHANGES TO YOUR MAILING ADDRESS

CHECK DATES FOR 2023: 1/26/2023 2/23/2023 3/28/2023
4/25/2023 5/25/2023 6/27/2023 7/26/2023 8/28/2023
9/26/2023 10/25/2023 11/27/2023 12/26/2023
Go Paperless and view EFT notices online up to 18 months.

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2022 pmts

GEORGETTE W KNECHT
PO BOX 937
VERDI, NV 89439-0937

DEPOSIT DATES MAY VARY DUE TO OFF-SITE DATA PROCESSING BY SOME BANKING INSTITUTIONS.

13122

ELECTRONIC FUNDS TRANSFER NOTICE - PERS FUND

#1077136

SCHEDULED DEPOSIT DATE:	**12/27/2022**		
GROSS AMOUNT:	**4,528.30**	RECEIVED YEAR TO DATE:	**17,509.34**
DEDUCTIONS:	**1,620.53**	TAXABLE YEAR TO DATE:	**17,509.34**
DEPOSIT:	**2,907.77**	RECEIVED TO DATE:	**17,509.34**

DEDUCTIONS:	MONTHLY AMOUNT	YEAR TO DATE AMOUNT
Federal Tax	**293.00**	**1,095.58**
MEDICAL PLAN 2	**1,327.53**	**2,655.06**

Two payments made through PERS Nov/Dec. '22

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9/26/2023 10/25/2023 11/27/2023 12/26/2023
Go Paperless and view EFT notices online up to 18 months.

2022 Pmts by Check

1889

SCOTT A KNECHT
GEORGETTE W KNECHT
420 LAKEVIEW DRIVE / PO BOX 9[illegible]
VERDI, NV 89439
775-345-0296

RECEIVED
NOV 0 2 2022
RISK MANAGEMENT
WASHOE COUNTY SCHOOL DISTRICT

11/2/22
Date

Pay to the Order of WCSD Insurance Fund $2655.06

Two thousand six hundred fifty-five 06/100 Dollars

Wells Fargo Bank, N.A.
Nevada
wellsfargo.com

For Sept/Oct 22

Two payments made by Check Sept/Oct'22